

DOCUMENT RESUME

ED 237 860

CG 017 115

AUTHOR Lambert, Dorinda J.
 TITLE Interventions for Dealing with Resistance.
 PUB DATE Aug 83
 NOTE 16p.; Paper presented at the Annual Convention of the American Psychological Association (91st, Anaheim, CA, August 26-30, 1983).
 PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)
 EDRS PRICE MF01/PC01 Plus Postage.
 DESCRIPTORS Behavior Change; *Behavior Modification; Change Strategies; Counseling Techniques; Emotional Response; *Hypnosis; *Intervention; *Psychological Patterns
 IDENTIFIERS *Psychoanalytic Theory; *Resistance (Psychology)

ABSTRACT

Basic intervention strategies for dealing with client resistance include psychoanalytic, learning/behavioral, and hypnotic/paradoxical. Psychoanalytic theory views resistance as a way to avoid the anxiety aroused by increasing awareness of unconscious materials and vulnerable areas in the person's life. Resistance is dealt with after it has occurred by confronting it through interpretation. The learning/behavioral approaches attempt to prevent the development of resistance by altering the format of information presented, by structuring the treatment using behavioral techniques, or by emphasizing client control in treatment planning. Hypnotic/paradoxical approaches are used either before or after resistance is evident. The client's resistance is used both directly (consciously) and indirectly (unconsciously) to facilitate change. Since the hypnotic/paradoxical approaches are relatively recent methods, theory development and effectiveness research are still needed. (Author/BL)

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ED237860

Interventions for Dealing with Resistance

Dorinda J. Lambert

University of Nebraska-Lincoln

Paper presented at the Annual Convention of the American
Psychological Association, August 1983.

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Interventions for Dealing with Resistance

ABSTRACT

Techniques for dealing with resistance are presented from three perspectives: psychoanalytic, learning/behavioral, and hypnotic/paradoxical. The Psychoanalytic approach deals with client resistance after it has occurred by confronting it through interpretation. The Learning/behavioral approaches attempt to prevent the development of resistance by altering the format of information presented, by structuring the treatment using behavioral techniques, or by emphasizing client control in treatment planning. Hypnotic/paradoxical approaches can be used either before or after resistance is evident; both indirectly utilize the client's resistance in order to facilitate change. Emphasis is placed on the need for development of theory behind the newer approaches and for research on the effectiveness of these techniques.

Interventions for Dealing with Resistance

My objective for this portion of the symposium is to present to you a sampling of the interventions available for dealing with resistance. I hope my presentation will touch on the techniques most interesting to you. Three areas will be addressed: (a) psychoanalytic, (b) learning/behavioral, and (c) hypnotic/paradoxical approaches. First, I will describe the techniques used in each of these areas as they relate to resistance. Then I will conclude my portion of the presentation by making some recommendations for research on the effectiveness of these interventions.

The Psychoanalytic Approach

The early Freudian approach characterizes resistance as a neurotic attempt to avoid insight into repressed materials while non-Freudians emphasize the adaptive or survival aspect of resistance (Singer, 1970). Agreement lies in their view that resistance functions to avoid the anxiety aroused by increasing awareness of unconscious materials brought forward by the therapists' interpretations. Current views emphasize that resistance provides protection for vulnerable areas of a person's life (Basch, 1982; Langs, 1980) and as such can communicate to the therapist where the problems lie. The focus can then be on the direct problem or on the secondary gains maintained by the resistance (Schlesinger, 1982; Weiner, 1982). Consequently, resistance forms when an interpretation threatens to lay open a painful area or suggests termination of the reinforcement achieved by the symptom. In this

perspective, resistance is the client's response to change prior to the intervention attempt.

Resistance may also be elicited by the therapist's incorrect use of interpretations. According to Spero (1977), resistance can be generated by poorly timed interpretations which are offered when the client does not have enough ego strength to deal with it. Therapists can also inadvertently generate resistance by making inappropriate interpretations of the patient's situation or by misdiagnosis (Basch, 1982). This suggests a recognition of the therapists' own contribution to resistance - a more recent development in the psychoanalytic approach (Langs, 1980; Saltmarsh, 1976).

Whether the cause of resistance is intrapsychic or interactional, the psychoanalytic treatment for resistance is interpretation. Based within a therapeutic relationship in which the client feels safe to explore and learn, the interpretation of the resistance can bring the unconscious significance of the resistance into the conscious mind. It is through the identification and verbalization of the unconscious intent of the resistance that the path to growth and change is re-opened (Blatt & Ehrlich, 1982; Langs, 1980; Saltmarsh, 1976; Spero, 1977; Weiner, 1982). This also allows the client to take responsibility in the treatment process (Hersen, 1971; Saltmarsh, 1976), thus leading to a greater sense that change is possible.

One variation of the interpretation technique entails the use of reality. Both Zucker (1967) and Protinsky and Maxwell (1977) propose that reality should be used in addition to the interpretation in order to counter resistance. In this view, resistance is the result of irrational thoughts and therefore, the therapist's task is to confront the irrational thoughts with reality. By keeping the focus on reality, the therapist helps the client identify and understand both the irrational beliefs held and their function which is protected by the resistance. Through the process of exposition and confrontation, the client may experience increased motivation to change as the resistance is overcome. The logical third step, teaching more rational beliefs or new behaviors, is not addressed in the psychoanalytic literature reviewed here but is one technique in the learning process which I will outline next.

The Learning/Behavioral Approach

While the psychoanalytic approach deals with resistance after it has occurred, the learning approach attempts to prevent its development. The techniques that I will now outline can be categorized into two groups: educational and behavioral.

Research on medical compliance has looked, in part, at how the format of the information presented affects patient compliance with medical instructions. Within the medical field, medical personnel have been continually stymied when confronted with patients who will not comply despite instructions concerning their medical regimen. This led medical professionals to look more

closely at their patient education procedures to determine how the presentation of information affects both memory and resulting behavior. Past research varied the composition of materials presented, for example, verbal presentation was compared with written presentation of the same materials. In reviewing this research, Becker and Maiman (1980) and Haynes (1976) found mixed results which suggest that knowledge in itself is not sufficient to produce compliance. To address this problem, Barofsky (1976) suggests a shift to the view of symptoms as a result of not only maladaptive learning but also possibly poor environmental controls. Thus, behavioral management principles could be added to the previous approaches for dealing with resistance.

The behavioral approach as applied to the medical compliance issue deals with the structure of the regimen itself in order to avoid the development of noncompliance. Some of the strategies used and reviewed by Barofsky (1976) and Haynes (1976) are (a) conditioning the medication schedule to the individual's personal and environmental cues, (b) use of differential reinforcement in shaping the new behaviors required by the medical regimen, (c) modeling new behaviors when instructing the patient, (d) use of desensitization for dealing with patient anxiety about the medical regimen, and (e) patient contracting. Patient contracting, in particular, has been seen as a way to tailor the medical regimen to the individual at the same time as emphasizing mutual responsibility in the process (Fink, 1976). Besides giving the

patient input into the process, such contracts provide information on behavioral expectations for both the patient and the professional, set goals, and incorporate reinforcers for compliance. There is also indication that the signing of a contract commits the patient to make the behavioral change and thus reduces resistance (Becker & Maiman, 1980).

The blend of cognitive and behavioral approaches provides the third perspective within the learning approaches to resistance. Meichenbaum and Gilmore (1982) view the internal dialogue of the person as intimately connected with affect and behavior and emphasize the therapeutic importance of reconceptualization of the problem by the patient. In this approach, then, therapy trains the client to use the scientific or problem-solving model to change beliefs and cognitions and in the process change behaviors. True to behavioral style, Meichenbaum and Gilmore recommend that the therapist adequately analyze the client's problem in order to first clarify whether it involves a deficit in knowledge, interpersonal skills, or whether it is due to ineffective cognitions like doubt or fear. Then treatment is individualized and structured to include a series of progressive, specific goals. These steps plus the continual involvement of the client in the planning and evaluation of homework contributes to the reduction of resistance.

Similarly, Guidano and Liotti (1983) emphasize two points for assuring therapeutic cooperation: the early presentation of the

rationale for the techniques used and the use of a therapeutic contract. Both steps place the client in the role of a therapeutic collaborator with some control in the relationship. This approach takes into account, therefore, the client's attitudes, beliefs, and cognitions about the possibility for change and from the start emphasizes the client's control in the process. This element of control is a major issue in resistance which is addressed by J. W. Brehm in his theory of psychological reactance. In this theory, reactance refers to a person's desire to avoid any directive that threatens one's freedom to choose (Brehm, 1976). Resistance can be viewed as the behavioral component of reactance. As mentioned previously, the behavioral and cognitive/behavioral techniques encourage client involvement and thereby incorporate client control into the therapeutic process. Possibly it is this element of planned collaboration with the patient that is the most effective tactic for dealing with resistance. Next, some uncommon approaches will be presented which utilize the person's resistance in helping them to change.

Hypnotic/Paradoxical Approaches

Two relatively new and interesting approaches to therapy and resistance are the utilization techniques developed by Milton Erickson and the use of paradox.

Milton Erickson, the innovator of modern hypnosis, offered through his practice and teachings a truly interesting approach to helping people change. By accepting each person as an unique

individual with resources and past learning, Erickson tailored each therapy to each client. Because he worked more with accessing the internal memories of a person in order to help them retrieve resources and past learning already present but not easily accessible, Erickson's techniques are described as indirect. His approach utilizes both the client's own behavior and thoughts to help create a new set of associations and thus, learning. Lankton and Lankton (1983) describe this as an attempt to get dominant and non-dominant hemispheres to communicate. Respect for the individual and the messages communicated in therapy are the result of the overall view that each individual already has resources within the self. Through acceptance of the client's statements, recognition of the values they represent, and timing and pacing strategies according to the person's response, the therapist works with the client at the client's level while utilizing the information gathered to help them change. This requires that the therapist change strategies quickly if one is found to be ineffective in the situation with that individual. There are many features that typify Erickson's approach; as summarized by Lankton and Lankton (1983), they are:

- 1) indirection - the use of indirect suggestion, binds, metaphors, and resource retrieval;
- 2) conscious, unconscious dissociation - multiple level communication, interspersal, double binds, multiple embedded metaphors; and

used mainly with resistant, chronic, and severe problem cases.

Some of these techniques are:

- (a) reframing - changing the frame of reference and therefore the meaning attributed to the situation;
- (b) relabeling - changing the name attached to the situation but not changing the frame of reference;
- (c) prescriptive paradox - a therapeutic double bind.

These may be used singly but are most often used in combinations with other paradoxical techniques. In their view, the most effective sequence of paradoxical methods is positive connotation, a prescription, and a restraining message.

Through paradoxical techniques, the therapist utilizes the individual's resistance to change in order to bring about change. There is much yet to be learned about their use and effectiveness.

Summary and Research Recommendations

Three broad theoretical approaches for dealing with resistance have been briefly presented. Interpretation is the psychoanalytic approach to resistance. Because the many interpretations of resistance may impede research, Hersen (1971) suggested that psychodynamic techniques be combined with behavioral techniques in order to quantify the phenomenon of resistance. Later, Spero (1977) attempted to implement this by defining resistance in terms of reinforcers of the symptoms. However, the seeming conflict between the psychodynamic and behavioral approaches may impede progress in such attempts.

The learning/behavioral approaches attempt to prevent the development of resistance and address the structure and composition of information presented to clients. Some behavioral management techniques suggested are: use of reinforcement, modeling, desensitization, and contracting. The use of client contracts has already generated research in the medical compliance area and warrants further exploration. Cognitive-behavioral techniques build on the issue of client control in the treatment process. The research of Meichenbaum and Gilmore (1982) has focused on client cognitions and their effect on behavior but more work is needed on the effectiveness of the modification of resistance using alternate cognitions. Jahn and Lichstein (1980) in their summary of the behavioral work on resistance present a system for the operational definition of resistance. They have linked each of Munjack and Oziel's (1978) types of resistance to a specific behavioral intervention. For example: relaxation training is used with resistance due to guilt and anxiety (a Type IV resistance) while contingency contracting is recommended for dealing with resistance due to secondary gain (Type V). This suggests areas for research to assess the effectiveness of the techniques identified with the behaviorally defined resistance.

Finally, hypnotic and paradoxical approaches to resistance were also presented. Research is greatly needed for clarification and definition of the utilization techniques of Milton Erickson and more specifically, the paradoxical techniques. The theoretical

base for such research is only recently beginning to form. Lankton and Lankton (1983) attempt to present Erickson's techniques with an eye to theory; Weeks and L'Abate (1982) present a dialectic meta-theory for paradoxical interventions. Growing interest in the development of theory in this area can greatly benefit future research on resistance.

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